DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

MENTAL HEALTH PARITY FOCUSED SURVEY

PILOT TEST #1

FINAL REPORT

PacifiCare of California

PacifiCare Behavioral Health of California, Inc.

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PacifiCare of California
Mental Health Parity Focused Survey Final Report
August 19, 2005

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducted a Focused Survey of PacifiCare of California (the "Plan") and PacifiCare Behavioral Health of California from March 7, 2005 to March 10, 2005. A "focused survey" assesses compliance of a particular aspect of plan operations with the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene"). In this case, the Focused Survey assessed compliance of the Plan's delivery of mental health services. (Section 1374.72 of the Health and Safety Code, Severe mental illnesses; serious emotional disturbances of children).

PacifiCare was the first focused survey completed of seven focused surveys conducted between March and June 2005. Plans that were surveyed are Knox-Keene licensed full service and, if applicable, specialty mental health plan delegates that administer and provide mental health benefits and services on behalf of the full service plan.

Health and Safety Code Section 1374.72, often referred to as the "**Parity Act**," requires full-service health plans to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions. Rule 1300.74.72 requires health plans to provide timely access and referral for the diagnosis and treatment of conditions set forth in Section 1374.72. The Rule also requires full-service health plans that contract with specialty mental health plans for the provision of mental health services to monitor the collaboration between the two contracting plans and ensure the continuity and coordination of care provided to enrollees.

The Plan delegates the provision of mental health services to PacifiCare Behavioral Health of California, Inc. (the "Delegate"). At the time of the survey, the Delegate provided mental health services to approximately 92% of the Plan's enrollees (See Appendix B).

Background

The Plan is a Knox-Keene licensed full service Health Maintenance Organization (HMO) providing health care coverage in California. The Plan was founded in 1975 by the Lutheran Hospital Society of California as a not-for-profit organization. In 1978, the Plan obtained its Knox-Keene license and began operations as a federally qualified HMO. The Plan changed to for-profit status in 1984 and the next year, PacifiCare Health Systems (PHS) was created as the national parent company of the Plan referred to by the staff as the "corporate". In the same year, Secure Horizons began operating as a federally qualified Medicare HMO. In 1992, the Plan changed its name to PacifiCare of California, Inc. and it also began operations as a federally qualified commercial Point of Service plan. In 1997, PHS completed its merger with FHP Inc., doubling the Plan's membership to 2.1 million enrollees.

PacifiCare Behavioral Health of California, Inc. is also Knox-Keene licensed, publicly traded, for-profit company, and a wholly owned subsidiary of PHS. It is affiliated with PacifiCare Life and Health Insurance Company. PacifiCare Behavioral Health of California, Inc. was founded as "Lifelink" in 1986 to provide managed mental health and substance abuse services. Lifelink received Knox-Keene licensure in 1992 for its managed care division.

On January 1, 1996, Lifelink formally changed its name to PacifiCare Behavioral Health of California, Inc., in an effort to better align with PHS and its subsidiaries. In the same year, the Plan acquired Psychology Systems, Inc., a behavioral health company based in Milpitas, California. Psychology Systems, Inc, provided both managed care and Employee Assistance Program products.

Survey Results

As part of the Focused Survey, the Department assessed the Plan's operations in the following four (4) major areas as they relate to the Parity Act: **Access and Availability of Services, Continuity and Coordination of Care, Utilization Management/Benefit Coverage,** and **Delegation Management**.

The Department identified four (4) compliance deficiencies in the Plan's implementation of and compliance with Section 1374.72. (See Section III, Table 1). The Plan has implemented corrective actions for these deficiencies. The Plan has corrected three (3) of these deficiencies. One (1) deficiency in the area of Access and Availability of Services remains uncorrected at the time of this Final Report.

Please refer to Section III for a detailed discussion of the deficiencies, the Departments findings, required corrective actions, the Plan's response and compliance efforts, and the Department's final determination regarding the status of the deficiencies.

SECTION I. FOCUSED SURVEY BACKGROUND

The Department's authority to conduct surveys comes from Knox-Keene, which mandates that the Division of Plan Surveys ("Plan Surveys") conduct on-site medical surveys of all licensed health plans at least once every three (3) years, including full-service and specialized plans. Full service health plans are defined as plans that provide all basic health care services. Specialized plans include behavioral health, vision, dental, and chiropractic plans.

In its planning for 2005, the Department's administration directed the Plan Surveys to design a focused survey process to review health plan compliance with enacted mental health parity laws. The project planning began in November 2004 and included three phases:

(1) Stakeholder input, inclusive of several meetings held to gather comments and identify issues currently voiced in the mental health community;
(2) Operations phase, included survey tool development and scheduling of the surveys; and
(3) Conduct the surveys.

The Department supports continued discussions with stakeholders and have received comments and suggestions throughout the project.

The purpose behind the focused surveys was to assess specific plan compliance and also to research some of the problems voiced by stakeholders, such as inadequate access to mental health providers and lack of payment of emergency mental health services. Meeting the challenges of implementation of the parity law from the health plan perspective was addressed with Plan management during the first day of the focused survey.

The Focused Survey Approach

The purpose of focused surveys is to afford the Department the ability to swiftly respond to potential serious health plan problems, concerns, or questions raised by consumers, legislators or other Department divisions on a particular issue. Subject matter of focused reviews could include assessment of compliance with newly enacted legislation, such as mental health parity or in some cases, specific applications such as Diabetes supplies regulations.

Although Section 1374.72 is reviewed by the Department for compliance as part of the normal Routine Medical Survey process, this focused survey approach allowed a more detailed look at application and compliance.

SECTION II. SCOPE OF WORK

The subject of this Focused Survey is Health and Safety Code Section 1374.72, Rule 1300.74.72, and other relevant sections of Knox-Keene, including but not limited to:

- Determining whether the plan and its contracted mental health plan have developed and maintained adequate provider networks to promote timely access to mental health services;
- Determining whether the plan and its contracted mental health plan are effectively coordinating the care of enrollees and providing continuity of care; and
- Determining whether the plan and its contracted mental health plans are authorizing and providing medically necessary services mandated under Section 1374.72 in an appropriate and timely manner.

Specifically, the Department assessed the Plan's operations in the following four (4) major areas as they relate to the Parity Act:

- **Access and Availability of Services** – to determine whether the Plan designs benefits for parity diagnoses under the same terms and conditions applied to other medical conditions, whether the Plan clearly communicates those terms and conditions to enrollees, and whether the Plan has developed and maintained adequate provider networks to assure enrollees timely access and referral to mental health services.
- **Continuity and Coordination of Care** – to determine whether the Plan provides appropriate continuity and coordination of care for enrollees with parity diagnoses.
- **Utilization Management/Benefit Coverage** – to determine whether the Plan appropriately authorizes and provides medically necessary treatment and services required under Section 1374.72 to enrollees with parity diagnoses.
- **Delegation Management** - when applicable, to determine whether the Plan adequately and appropriately oversees its contracted specialty mental health plan and ensures that parity mental health services are provided to enrollees with parity conditions in a timely and appropriate fashion, under the same terms and conditions applied to medical conditions.

SECTION III. SURVEY FINDINGS

The table below lists deficiencies identified during the Focused Survey. The Department issued a Preliminary Report to the Plan regarding these deficiencies on April 20, 2005. In the Report, the Plan was instructed to: (a) develop and implement a corrective action plan for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

TABLE 1

#	SUMMARY OF DEFICIENCIES	Status
A. ACCESS AND AVAILABILITY OF SERVICES		
1	**The Plan's written policy does not correctly describe the Plan's obligations to provide coverage for the diagnosis and treatment of a person of any age with pervasive developmental disorder or autism in accordance with Section 1374.72.** [Section 1374.72(a)-(e) Rule 1300.74.72(e)]	Corrected
2	**The Plan does not adequately monitor and evaluate accessibility of care, including the provision of after-hour services.** [Rule 1300.67.2(b) Rule 1300.67.2(f) Rule 1300.74.72(f)]	Not Corrected FURTHER ACTION REQUIRED
B. UTILIZATION MANAGEMENT/BENEFIT COVERAGE		
3	**For denials of health care services based in whole or in part on a finding that the proposed services are not a covered benefit under the contract, the Plan failed to clearly specify the provisions in the contract that exclude that coverage.** [Section 1368(a)(5)]	Corrected
4	**The Plan incorrectly and inappropriately denies payment for emergency claims**. [Section 1371.37 Section 1371.4]	Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: The Plan's written policy does not correctly describe the Plan's obligations to provide coverage for the diagnosis and treatment of a person of any age with pervasive developmental disorder or autism in accordance with Section 1374.72. [Section 1374.72 (a)-(e), Rule 1300.74.72(e)]

Documents Reviewed:

- Joint Policy on the Management of Members with Autism and Related Pervasive Developmental Disorders (No. UM 1.32)

Department Findings: The Plan's written policy does not correctly describe the Plan's obligations to provide coverage for the diagnosis and treatment of a person of any age with pervasive developmental disorder (PDD) or autism under the same terms and conditions applied to other medical conditions. The policy stipulates in Item #3, "Treatment Phase," "The *cornerstone* (emphasis added) of service access and provision throughout the life span of a member with autism and related PDDs are the Regional Centers or Early Intervention Centers. Children under the age of 3 and individuals past school age are the *sole responsibility* (emphasis added) of the Early Intervention Centers or Regional Centers."

Section 1374.72 requires the Plan "provide coverage for the diagnosis and medically necessary treatment of . . . pervasive developmental disorder or autism . . . under the same terms and conditions applied to other medical conditions. . . "

Interviews with the Delegate's Medical Director, the Director of Utilization Management, the Manager of Clinical Operations, and the case manager with responsibility for working with parents of autistic children who require speech and/or occupational therapy revealed that, <u>in practice</u>, the Delegate provides the full range of evaluation and ancillary services, in addition to mental health services, when

(1) these services are not available through the Early Intervention Centers or the Regional Centers; or
(2) a parent chooses not to access services through an Early Intervention Center or the Regional Center.

The Delegate case manager explained that because Regional Centers are the recognized source for the provision of Autism-related health services, including comprehensive evaluations and speech and occupational therapies, it is common practice to inquire from the parents whether an attempt has been made to access the Regional Centers' services or whether the child is receiving services through the Early Intervention Centers or the Regional Centers.

Implications: When a verbal description of the Plan's operational practice runs counter to a written policy, the Department must confirm the Plan is correctly interpreting, implementing and applying the law.

While Plan management asserts the Plan does not limit the provision of services for the diagnosis and treatment of autism-spectrum services to children under the age of three (3) and through the age of 17, the existence of a written policy that suggests otherwise and raises a potential compliance issue that must be traced to a level of service delivery. In addition, inaccurate written policies, typically followed by new or less experienced staff, create a potential for inappropriate handling of covered benefits, either during initial benefit determinations or during the course of appeals.

Corrective Action:

(1) The Plan shall provide evidence that it has revised and corrected Policy No. UM 1.32, "Joint Policy on the Management of Members with Autism and Related Pervasive Developmental Disorders."

(2) The policy must state clearly the Plan's responsibility to provide the full range of evaluation and treatment services to children with PDD and/or autism.

(3) The Plan shall sample and review a statistically significant number of benefit interpretations by staff, either during initial determination or during the course of appeals, for members seeking treatment with a diagnosis of autism and/or PDD.

(4) The sample should be taken after the effective date of the original policy UM. 1.32.

(5) The plan must show evidence to the Department that all determinations comply with section 1374.72.

Plan's Compliance Effort: The Plan stated that it has revised UM Policy 1.32 "Joint Policy on the Management of Members with Autism and Related Pervasive Developmental Disorders." The new policy is referred to as UM Policy 1.56 and it addresses the deficiencies noted by the Department. UM Policy 1.56 explains the Plan's primary responsibility to provide the full range of evaluation and treatment services to children with PDD or autism.

Specifically, UM 1.56 stipulates that the Plan has joint responsibility in coordination with its full service health plan partners to provide coverage for the diagnosis and treatment of a person of any age with PDD or autism under the same terms and conditions applied to other medical conditions. The Plan authorizes and provides benefit coverage for the full range of behavioral healthcare services that are medically necessary and appropriate, including the following:

- Outpatient services, including psycho-educational services to family members
- Inpatient hospital services
- Partial hospital services

The terms and conditions applied to these benefits are applied equally to all benefits under the

plan contract, including but not limited to, the following:

- Maximum lifetime benefits
- Co-payments
- Individual and family deductibles, where applicable

To address the noted Corrective Action Items 3-5, the Plan stated it conducted an audit to evaluate the interpretation and application of benefits for pervasive developmental disorders (PDD) and autism. Examined was compliance with Section 1374.72, which requires the Plan "provide coverage for the diagnosis and medically necessary treatment of . . . pervasive developmental disorder or autism . . . under the same terms and conditions applied to other medical conditions …" A comprehensive analysis was completed of all claims and clinical records after the original effective date of Clinical Policy and Procedure UM 1.32. All cases from March 2001 to present were pulled to identify the universe of PDD and autism cases. Identified for that time period were 999 cases with diagnoses of PDD and autism. From the 999 cases, 210 were pulled by a random sample to produce a statistically valid audit sample at the 90% confidence level. Of the random sample, all 210 cases were reviewed. The compliance rate for the cases reviewed for benefits interpretation (n=210) was 100%; compliance based on benefits coverage (authorized and paid as requested). Of the 210 cases, there were three (n=3) denials issued. Additional review of the three denial cases occurred to assure that the denial was issued based on medical necessity criteria and consistent with Plan policies and procedures. There were no issues identified with the denial file review; decisions were appropriately made in all cases based on medical necessity criteria.

The Plan submitted the following documents:

- UM Policy 1.56 Joint Policy on the Management of Members with Autism and Related Pervasive Developmental Disorders (California Only)
- A report outlining a review of benefit interpretations for PDD and Autism

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been fully corrected.

The Department finds that the Plan has made appropriate changes to its Joint Policy on the Management of Members with Autism and Related Pervasive Developmental Disorders to clearly state the Plan's responsibility to provide the full range of evaluation and treatment services to children with PDD and/or autism. Through the results of an internal audit, the Plan also demonstrated that its staff had been correctly interpreting the application of benefits with regard to the Plan's obligations to provide coverage for diagnosis and treatment of PDD and autism.

Deficiency 2: The Plan does not adequately monitor and evaluate accessibility of care, including the provision of after-hour services. [Rule 1300.67.2(b), Rule 1300.67.2(f), and Rule 1300.74.72(f)]

Documents Reviewed:

- Provider Manual
- Provider contract templates
- Plan website

Department Findings: The Plan provides enrollees 24-hour-a-day/365-days-a-year access to behavioral health assessment by a master's level clinician through a toll-free Member Services telephone line operated by its Delegate. By means of this 24-hour telephone service, enrollees receive evaluation and referral for appointments, crisis intervention, and, if necessary, arrangements for emergency care or hospitalization.

While these call-in services are available 24 hours a day, the Plan does not ensure that the Delegate's providers are available during normal business hours or after-hours should an enrollee attempt to contact his/her provider directly. Provider contracts do not include emergency or after-hours availability requirements. The Provider Manual requires that providers ensure 24-hour emergency availability and that they are available within four (4) hours of an emergency. However, the Plan does not have a formal method to monitor provider compliance with these standards. Because many mental health service providers operate in solo practices and are often not available to answer the phone even during normal business hours (e.g., during counseling sessions), they rely on answering machines or services to take messages from enrollees who need to make direct contact with their mental health provider during normal business hours. Consequently, the presence and content, as well as whether the call was returned in a timely manner, are critical components of provider availability.

The Department noted that, at the time a provider is initially credentialed for network participation, the Plan conveys to the provider that emergency coverage is required. The Plan also requires that all providers give new patients written emergency contact information, and the Plan monitors the provision of this information through its periodic medical record audits. The Department performed telephone surveys of providers both during and after normal business hours. The purpose of the surveys was to assess the presence and content of answering service/machine messages, provider responsiveness, appointment availability, and whether the practice was open to new patients.

The first survey was conducted on 30 providers during normal business hours. As part of this survey, if there was not a live answer to the call, the Department assessed the following:

(1) whether an answering machine message or service was in place; and
(2) whether the message contained instructions for emergencies (i.e., a pager number or answering service by which the enrollee could reach the provider and instructions to contact 911 in case of an emergency).
(3) The Department also left a message requesting a return call and monitored whether a return call was received within 24 hours.

The Department found that, of the 26 calls that did not result in a live answer, all had a messaging system. However, eight (8) did not contain instructions regarding the use of 911 for emergencies. Nine (9) of the 26 did not respond with a return call within 24 hours.

The Department also performed a telephone survey of 10 providers after normal business hours to assess the presence and content of answering service/machine messages. Two (2) calls resulted in a live answer via an answering service. Of the eight (8) that were not immediately answered, all had automatic message systems; however, three (3) did not provide any instructions for emergency situations.

The following table summarizes the results of the telephone survey.

TABLE 2: TELEPHONE SURVEY OF PROVIDERS

TOTAL CALLS			IF NO LIVE ANSWER				IF INITIAL LIVE ANSWER OR CALL BACK RECEIVED	
Sample type and Size	Live answer	No live answer	Answering machine message or service present	Direct enrollee to 911	Additional emergency instructions (e.g., pager, crisis line #)	Call back received within 24 hours	Open to new patients	Meets Plan's routine appointment availability standard of 10 working days
Calls during business hours N=30	4	26	26	18	7	17	21	20
Calls after hours N=10	2	8	8	5	0	N/A	N/A	N/A

Implications: Although an enrollee may initially use the 24-hour Member Services line to arrange for services and may call the line at any time to arrange for emergency care, once an enrollee has established a therapeutic relationship with a provider, that enrollee may attempt to contact the provider prior to or instead of contacting the Plan or its Delegate in an emergent or urgent situation. For this reason, health plans must ensure access to individual providers after hours and/or must provide clear instructions via provider messaging systems on how patients may contact the provider and/or other sources of assistance.

Corrective Actions: The Plan shall provide evidence that all providers have received clear and detailed instructions regarding after-hours coverage and messaging. The Plan shall also provide evidence that it has established a system for monitoring the presence and appropriateness of the providers' messages in their answering systems.

Plan's Compliance Effort: The Plan stated that it has provided instructions regarding after-hours coverage and messaging requirements through a supplement to the California Provider Manual. Such instructions were also added to the Plan website and placed on the Provider home page. The new manual is inclusive of the Member Communication, Office Voicemail, and Emergency/After-hours Contact Process Expectations. In addition, the Plan further stated, the California outpatient network, in its entirety, was mailed a letter detailing the publishing of a

new California Provider Manual Supplement and was directed specifically to review the clarified and more detailed expectations for after-hours and emergency availability and access.

The Plan created Policy QI 2.45 to establish monitoring of access criteria and communication standards for providers, as well as provider practice communication systems. The Plan stated that audits and random monitoring will be completed in accordance with the access criteria outlined in the Practitioner Contact/Telephone System Audit Tool. Follow up with providers will occur in a timely fashion until the system meets expectations or the provider contract may be terminated. Failure of a system to fully comply with the expectations will result in corrective action planning for the provider as outlined in the policy.

As a means of executing random monitoring, the Plan stated it has implemented a process to use outbound calls made by clinical staff members to monitor provider compliance to access and communication standards. On an annual basis Plan clinical staff members make over 107,000 outbound calls, 24 hours a day. As these outbound calls include times when there is no live-answer and after-hours, they serve as a unique source of insight into the telephone and contact systems of contracted practitioners and groups in California.

Furthermore, the Plan stated that clinical team members and customer service representatives who make these outbound calls have received training and education in monitoring providers for after-hours and emergency access standards. These staff members are able to access an EIC (Employee Identified Concern) form to transmit concerns and initiate a quality review when provider systems fail to meet these standards. These concerns then move through the Quality Improvement process and route to Provider Network Management directly for review and follow up. The Plan stated it already utilizes a telephone access complaint category for member complaints, which results in the same follow up procedures. The Plan envisions Provider Network Management, Quality Improvement and Clinical Operations to work together to determine specific system failure, make a detailed review of the system, provide feedback to the provider, and oversee corrective action planning as needed.

The Plan submitted the following documents:

- PacifiCare Behavioral Health Provider Manual 2005
- Letter detailing Provider Manual Revision
- Policy QI 2.45, "Practitioner Accessibility and After-Hour Communication"
- Document detailing the Practitioner Contact/Telephone System Audit Tool
- EIC (Employee Identified Concern) form

Department's Finding Concerning Plan's Compliance Effort:

STATUS: NOT CORRECTED

The Department finds that the portion of this deficiency regarding providers' receipt of clear and detailed instructions regarding after-hours coverage and messaging has been corrected. The Department finds that the Plan has made and distributed appropriate changes to its Provider Manual to incorporate this information.

However, the Department finds that the portion of the deficiency regarding establishment of a system for monitoring the presence and appropriateness of providers' messages in their answering systems has not been fully corrected. The primary approach proposed by the Plan is monitoring performed concurrent with calls made by clinical staff. While the Department agrees that monitoring performed concurrent with clinical staff phone calls will allow for contact with a large number of providers, it is not clear from the Plan's response how this method will ensure that all providers are included in the monitoring and how often each will be monitored. Because the calls occur when providers are contacted for other reasons, the process does not appear to ensure that all providers will be included at some point in the oversight.

Additionally, because the selection of providers is based upon the calls rather than on a full or statistically random selection of providers, some providers may be monitored multiple times while others may not be monitored at all. The policy does not address whether or how these multiple calls will be removed from the denominator in order that valid Plan-wide compliance rates can be calculated.

The policy also does not address whether new providers will be assessed for compliance prior to entry into the Plan's network (e.g., through an initial call, onsite monitoring), which appears to allow for the possibility of provider participation for an undetermined amount of time without the presence of an appropriate messaging system.

FURTHER ACTION REQUIRED: Within 30 days of receipt of this Final Report, the Plan is to provide an updated Policy and Procedure that addresses the concerns that the Department has identified with the current monitoring system. In addition, the Plan is to provide evidence that the new procedure has been implemented to ensure that all providers are monitored for after-hours access.

B. UTILIZATION MANAGEMENT / BENEFIT COVERAGE

Deficiency 3: For denials of health care services based in whole or in part on a finding that the proposed services are not a covered benefit under the contract, the Plan failed to clearly specify the provisions in the contract that exclude that coverage. [Section 1368(a)(5)]

Documents Reviewed:

- 22-benefit denial files from the period June through December 2004

Department Findings: The Department reviewed the files for 22 cases in which payment was denied because the service was not a covered benefit. Instead of providing a specific reference page, or excerpt from the member's Evidence of Coverage that describes the benefit exclusion, all the Plan's denial letters referenced the exclusion in a standard statement,

"As described in the member's Evidence of Coverage and Disclosure Form, the member's benefit plan does not include any provision for coverage for. . . ."

The table below summarizes the findings of the Department's file review:

TABLE 3: BENEFIT DENIALS

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# (%) COMPLIANT	# (%) DEFICIENT
Benefit Denials	22	Benefit coverage denial letters must specify the provision in the enrollee's contract or Evidence of Coverage/Disclosure Form that excludes that coverage.	0 (0%)	22 (100%)

Implications: The Plan's system for generating benefit denial letters is in violation of Section 1368. Full and clear disclosure of benefit exclusion and limitations provides the enrollee a concise explanation and full understanding of the scope of covered health care benefits. Under Section 1368, the Plan has a duty to inform the enrollee of the specific contract provisions excluding coverage.

Corrective Action: The Plan shall provide evidence that it has revised its standard benefit denial letter to specify the relevant provisions of the Evidence of Coverage/Disclosure Form through one of the three following options:

(1) Citing the benefit exclusion or limitation in the enrollee's Evidence of Coverage/Disclosure Form by page number and section (this assumes the enrollee possesses and can reference an up-to-date copy of the Evidence of Coverage);
(2) Quoting the language in the Evidence of Coverage /Disclosure Statement that excludes or limits the benefit within the body of the letter; or
(3) Attaching a copy of the pertinent section of the Evidence of Coverage/Disclosure Form to the denial letter.

The Plan shall provide the Department copies of a random sample of twenty-two revised denial letters following the required change.

Plan's Compliance Effort: The Plan stated that it has revised its standard benefit denial letter to specify relevant provisions of the Evidence of Coverage (EOC)/Disclosure Statement. The Plan's denial language has been modified to reflect the language in the EOC/Disclosure Statement that excludes or limits the benefit within the body of the letter. The Plan stated that the revised letters will be implemented on June 6, 2005. A sample of twenty-two letters issued between June 6-30, 2005 will be provided to the Department by July 8, 2005.

The Plan submitted the following documents:

- Copy of standard benefit denial letter

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been fully corrected.

The Department finds that the Plan has made appropriate changes to its standard benefit denial letter to specify relevant provisions of the Evidence of Coverage/Disclosure Statement. The Plan implemented the change beginning June 6, 2005 and submitted the sample of letters on July 8, 2005. The Department reviewed the letters and found them to be compliant.

Deficiency 4: The Plan incorrectly and inappropriately denies payment for emergency claims. [Section 1371.37 and Section 1371.4]

Documents Reviewed:

- Emergency service claims from June through December 2004

Department Findings: The Department reviewed 20 ER claims from non-participating providers and 15 ER claims from participating providers. Six (6) of the 20 non-participating providers' claims were from county facilities. The Department found that the Plan inappropriately denied over half (57%) of the ER claims processed.

The Department's findings are summarized below:

TABLE 4: ER CLAIMS DENIALS

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# (%) COMPLIANT	# (%) DEFICIENT
Non-Par ER Claims	20	Appropriate denial	8 (40%)	12 (60%)
*County facility	6		4	2
Par ER Claims	15	Appropriate denial	7 (47%)	8 (53%)
Total no. of files	35		15 (43%)	20 (57%)

* Six of the Non-Par ER claims were from county facility providers

The Plan uses the prudent layperson rule when processing ER claims. The Plan's policies for processing emergency service claims are the following:

- Automatic Payment: ER claims are automatically paid if they include codes (revenue code 450 or ICD-9 E codes) that indicate possible suicide or if the medical record attached to the claim indicates suicide or attempted suicide.
- Denial: Claims are denied if they do not contain revenue code 450 and do not have medical records attached. The Plan uses denial code "DNE," which means that it needs the medical record to review the claim for medical necessity.
- Medical Review: ER claims with medical records attached are to be forwarded for medical review to determine medical necessity. Alternatively, if the claims examiner reviews the attached medical record and finds indication of suicide or suicide attempt, the examiner can pay the claim without medical review.

The Department found that the Plan did not pay claims in accordance with its policies. Claims with codes that qualified for automatic payment were denied for lack of authorization. The Plan also denied three (3) out of 35 claims with medical records attached for lack of authorization. According to Plan policy, these claims should have been forwarded for medical review, or the examiner should have reviewed the medical record for indication of suicide or attempted suicide. Plan staff agreed with the Department's findings, and stated that it has initiated staff training regarding correct application of ER payment policies.

Implications: Incorrect denial of payment for health care services to which enrollees are entitled breaches the agreement between the enrollee and the plan for covered services, may create a barrier to future services based on previously denied payments and result in providers inappropriately billing enrollees for these services.

Corrective Action:

(1) The Plan shall develop and implement an internal audit program designed to monitor compliance with its ER claims processing policies and procedures.
(2) Specific audit criteria shall include, but not be limited to,
    a. total # and % of ER claims that qualified for automatic payment
    b. total # and % of ER claims that qualified for and were automatically paid
    c. total # and % of ER claims that were referred for medical review
    d. Accuracy of medical review determination, based on statutory requirements
(3) Files selected for audit should include appealed cases as well as initial determinations.
(4) File sampling method should be proportional to the total number of facility types (participating, county, other) from which the Plan receives ER claims. For example, if claims from county facilities account for 20% of the Plan's total ER claims, then 20% of the ER claims selected for audit should be from county facilities.
(5) The Plan shall establish an implementation date for the audit program, which should not be later than two (2) months from the date of this Preliminary Report, and include the implementation date in its response to this Preliminary Report. Audit results should be reported to the Department, within a reasonable time frame, after the first three (3) and six (6) months of the implementation date.

Plan's Compliance Effort: The Plan stated that since the Focused Survey in March 2005, the Plan has audited all emergency claims for 2005. The following results were reported:

Results

- The review of the 538 claims resulted in a finding that 106 were found to have inappropriate decisions. These claims were corrected and paid.
- The review of the 770 claims resulted in a finding that 34 were found to have inappropriate decisions. These claims were corrected and paid.

Actions

Based on Department and Plan audit findings, the following occurred:

- The Emergency Claims policy was revised.
- All examiners received training of decision making related to emergency service claims.

The Plan stated that while the recent audit findings confirm that the training and auditing activities generated an improvement in performance, focused review of denied emergency claims will continue during June 2005. Effective July 1, 2005, the Plan will implement an internal audit program designed to monitor compliance with ER claims processing and procedures requirements described in Section 1371.37 and Section 1371.4. Audit criteria will include:

- Total # and % of ER claims that qualified for automatic payment;
- Total # and % of ER claims that were referred for medical review; and
- Accuracy of medical review determination, based on statutory requirements.

The Plan explained that audit monitoring of the "Total # and % of ER claims that qualified for and were automatically paid," will not be applicable since emergency claims currently do not qualify for automatic adjudication.

The Plan assured the Department that it will continue to perform 100% audits on a monthly basis until the implementation of the new audit program in July 1, 2005. Once the program has been implemented, the Plan will report audit results to the Department within a reasonable timeframe, after the first three (3) and six (6) months of the implementation date.

The Plan submitted the following documents:

- Results of emergency services audit of claims received January 2 – May 24, 2005
- Policy CL-E2-DMHC: Emergency Services Claims Audit

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been fully corrected.

The Department finds that the Plan has made appropriate revisions to its policy to establish an appropriate audit program for ongoing monitoring of a sample of its ER claims. The Plan has committed to implementation of the sample audit program by July 1, 2005 and will submit its results following the first three (3) and six (6) months of the implementation date for the Department's review.

To ensure an immediate resolution of the issue, the Plan implemented training of its claims examiners, a retrospective review on 100% of emergency claims (n=538) received January 2, 2005 - March 31,

2005, a prospective review of 100% of emergency claims (n=770) received subsequent to the Department's visit (April 1, 2005 - May 24, 2005) and ongoing monitoring of 100% of claims until the sample audit program is fully implemented in July, 2005. The Department's review of the audit results showed that: (a) the training and policy change have resulted in improved decision-making regarding payment, and (b) erroneous decisions have been identified and corrected.

C. SURVEY CONCLUSIONS

The Department has completed its Focused Survey of the Plan. The Department will continue to monitor the Plan's compliance with the provisions of the Parity Act through its Routine Medical Surveys, which are conducted at least once every three (3) years.

The Department will develop a Summary Report that aggregates and analyzes the Parity Focused Survey results of all plans surveyed by Fall 2005. The Summary Report will be available to the plans and to the public through the Department's Public File.

A P P E N D I X A

METHODOLOGY & PARAMETERS

A. Review Methodology

The Department conducted a Focused Survey of the Plan from March 7, 2005 to March 10, 2005, at its Delegate's offices in Van Nuys, California, to evaluate the Plan's compliance with Section 1374.72. The Department conducted the survey utilizing the clinical expertise of four licensed professionals, including two board-certified psychiatrists and a licensed clinical social worker.

Survey activities included the review of plan documents, enrollee case files, and claims. The Surveyors conducted interviews with officers and staff from the Plan and its Delegate. Surveyors also telephoned 40 participating providers to assess appointment availability and evaluate the providers' after-hours telephone message in regard to the provision of emergency services. Each survey activity is described in greater detail below.

Review of Plan documents – The Department reviewed a number of additional materials to assess various aspects of Plan compliance, for example:

- Policies and procedures for all related activities
- Internal performance standards and performance reports
- Communications regarding benefits
  - Explanation of coverage
  - Explanation of benefits
- Materials demonstrating continuity and coordination of care
  - Reports on inpatient admissions, office visits and other services provided
  - Clinical practice guidelines and protocols
  - Case management program descriptions and case files
- Reports on access and availability of services
  - Number and geographic distribution of clinicians, facilities and programs
  - Appointment availability
  - Timeliness of answering the triage and referral telephones
- Reports demonstrating the Plan's oversight of any activities performed by its Delegate

Review of enrollee case files: Prior to the on-site visit, the Department requested logs for a number of Plan activities, e.g., utilization review, claims processing, case management, etc. From these, the Department selected samples of case files for a comprehensive review. Review focused on measures such as appropriateness of denials of services, timeliness of decision-making, and coordination of care, as well as the appropriate exchange of information among providers.

The review of utilization management files was performed with the participation of Plan staff. Table 1 below displays the categories of utilization management files reviewed and the sample sizes selected.

TABLE 1: FILES REVIEWED

CATEGORY OF FILE	SAMPLE SIZE
Utilization Management - Medical Necessity Denials for Children with Autism or Seriously Emotionally Disturbed Children	20
Utilization Management - Medical Necessity Denials for Other Individuals	30
Utilization Management - Benefit Denials for Children with Autism or Seriously Emotionally Disturbed Children	10
Utilization Management - Benefit Denials for Other Individuals	12
Utilization Management - Denials of Non-Formulary Pharmaceuticals	10
Continuity and Coordination of Care – Case Management Files	5

Review of claims – Prior to the on-site visit, the Department requested claims listings. From these, the Department selected samples of claims for comprehensive review. Review focused on measures such as the appropriateness of denial and the accuracy of payment based on mandated parity benefits. The review of claims files was performed with the participation of Plan staff. Table 2 below displays the categories of claims reviewed and the sample sizes selected.

TABLE 2: CLAIMS FILES REVIEWED

CATEGORY OF CLAIM	SAMPLE SIZE
Claims for emergency services from non-participating providers	20
Claims for emergency services from participating providers	15

Interviews – The Department interviewed staff from both the Plan and Delegate to augment the review of documents and obtain a comprehensive picture of Plan activities surrounding the implementation of Section 1374.72, as well as to discuss the specific files, claims and documents the Department reviewed. The list of individual officers and staff members interviewed, along with their respective titles, may be found in Appendix C. The list of the Department's survey team members who conducted the interviews may be found in Appendix D.

B. Utilization Management File Review Parameters

The parameters assessed during the review of each file included (as appropriate to each sample type):

- Diagnoses
- Accuracy of case categorization (parity vs. non-parity)
- Decision rendered/action taken by plan (approval or denial)
- Adequacy of clinical information obtained to support decision-making
- Documentation of rationale supporting the decision rendered
- Accuracy of decision based upon statutory requirements and
- Consistency between decision and communication sent to the affected practitioner/provider and member

C. Claims Review Parameters

The parameters assessed during the review of claims included:

- Diagnoses
- Accuracy of claim categorization (parity vs. non-parity; participating vs. non-participating; and emergency vs. non-emergency)
- Adequacy of administrative and clinical information obtained to support denial decision-making
- Appropriateness of denial
- Documentation of referral to medical review prior to denial decision rendered
- Accuracy of documented denial reason based upon plan policies regarding claim processing
- Accuracy of payment based on mandated parity benefits and
- Appropriateness and accuracy of communication sent to the affected practitioner/provider and enrollee

A P P E N D I X B

OVERVIEW OF PLAN OPERATIONS

A. Plan Profile

The tables below summarize the information submitted to the Department by the Plan and its Delegate in response to the Pre-Survey Questionnaire:

PLAN PROFILE

Type of Plan	**Full Service Plan**	
Specialized Health Care Service Plan(s) or Mental Health Plan(s) with which the Plan Contracts for (i.e., delegates) Provision of any 1374.72 Services as of March 10, 2004	**Knox-Keene Licensed Behavioral Health Plan**	**Enrollees**
	PacifiCare Behavioral Health of California, Inc.	1,202,000 (92%)
	Health Management Center (HMC)	77,000 (6%)
	Managed Health Network (MHN)	3,000 (0%)
	Value Options	14,000 (1%)
	Vista Behavioral Health	3,000 (0%)
	United Behavioral Health (UBH)	14,000 (0%)
	Total	**1,313,000 (100%)**
Number of Enrollees Covered by Mental Health Parity as of February 2005	**Product Lines**	**Enrollees**
	PacifiCare of California Commercial HMO	1,135,294
	PacifiCare of California Commercial POS	27,126
	Total	**1,162,420**

Service Area(s) *(Counties, in full or in parts)*	Alameda Contra Costa El Dorado Fresno Imperial Kern Kings Los Angeles	Madera Marin Merced Nevada Orange Placer Riverside Sacramento	San Bernardino San Diego San Francisco San Joaquin San Luis Obispo San Mateo Santa Barbara Santa Clara	Santa Cruz Solano Sonoma Stanislaus Tulare Ventura Yolo

Plan Identification of Enrollees Eligible for Parity Services
Adults: Adults who are eligible for parity services are identified through the diagnosis that the practitioner identifies on the claim form and/or the Provider Assessment Request. If there are unclear or conflicting diagnoses, the care manager will contact the provider to verify the diagnosis.
Seriously Emotionally Disturbed Children: The Delegate considers any enrollee under the age of 18 who has a DSM-IV diagnosis, other than a chemical dependency diagnosis, to be a SED child/adolescent who is eligible for parity benefits.

MENTAL HEALTH PROVIDER NETWORK

Practitioners that Treat Adults	Number in the Network
Psychiatrists	1,153
Doctoral-level psychologists	1,655
Mental health nurse practitioners with furnishing numbers	23
Other mental health nurse practitioners	16
Marriage and Family Therapists (MFT)	2,606
Licensed Clinical Social Workers (LCSW)	1,031
Other: Physician Assistant (Prescriber)	1
Total	**6,485**

MENTAL HEALTH PROVIDER NETWORK
(Continued)

Practitioners that Treat Children and Adolescents	Number in the Network
Psychiatrists	Adolescents – 497 Children – 262
Doctoral-level psychologists	Adolescents – 1,169 Children – 714
Mental health nurse practitioners with furnishing numbers	Adolescents – 10 Children – 3
Other mental health nurse practitioners	Adolescents – 8 Children – 0
MFTs	Adolescents – 1,934 Children – 1,141
LCSWs	Adolescents – 752 Children – 450
Other: Physician Assistant (Prescriber) Speech Therapists Occupational Therapists	 Adolescents – 1 Adolescent & Child – 17 Adolescent & Child – 10
Total	Adolescent – 3,901 Children – 2,597

MENTAL HEALTH PROVIDER NETWORK
(Continued)

Programs and Institutional Providers that Treat Adults	Number in the Network
Acute inpatient units—voluntary admissions	81
Acute inpatient units—involuntary admissions	81
Crisis treatment centers/programs	0[1]
Intensive outpatient treatment programs/partial hospitalization	134
Residential treatment programs	7
Eating disorder programs	19
Others: SMI Adult Programs – such as Wraparound Services Speech, Language and Occupational Therapy Programs	 10 36

Programs and Institutional Providers that Treat Children and Adolescents	Number in the Network
Acute inpatient units—voluntary admissions	45
Acute inpatient units—involuntary admissions	45
Crisis treatment centers/programs	0 (see previous footnote)
Intensive outpatient treatment programs/partial hospitalization	78
Residential treatment programs	20
Eating disorder programs	16
Others: Programs specific to SED and Autism – such as Wraparound Services Speech, language and occupational therapy programs Autism evaluation clinics	 11 36 8

[1] The Delegate does not contract specifically with Crisis Treatment Centers (often called CSUs). These are generally programs such as County Mental Health Agencies, which most often do not enter into private contracts due to their pubic and Medi-Cal contracts. The Delegate does, however, pay for the services rendered in these facilities when they are accessed for emergency care.

ACCESS AND AVAILABILITY STANDARDS

Type of Practitioner	Ratio of Practitioners to Enrollees	Geographic Availability	Percent of Open Practices
Psychiatrists (Includes prescribers)	1:1000	**MSA – Mileage** Level A – 1 in 15 miles Level B – 1 in 20 miles Level C – 1 in 25 miles Level D – 1 in 30 miles	(See footnote) [2]
Doctoral-level psychologists	1:500[3]	**MSA – Mileage** Level A – 2 in 5 miles Level B – 2 in 10 miles Level C – 2 in 15 miles Level D – 2 in 20 miles	(See footnote 4)
Mental health nurse practitioners with furnishing numbers	These fall under a general "Prescriber" category. See "Psychiatrist" category		(See footnote 4)
Master's prepared therapists	1:500 (see footnote 5)	**MSA – Mileage** Level A – 2 in 5 miles Level B – 2 in 10 miles Level C – 2 in 15 miles Level D – 2 in 20 miles	(See footnote 4)

[2] The Delegate does not set standards for "Open Practices" but rather monitors the network for access compliance quarterly, monitors for and responds to access complaints by increasing the network access as needed, makes best efforts to keep practitioners off of leave of absence status through rate and process negotiations and annually contacts those on leave to encourage a return to active status after they have placed themselves on leave.

[3] The Delegate requires at least one licensed therapist for every 500 members. The Delegate does not require separate and specific ratios across the various license levels, such as Masters- versus Doctorate-level psychologist ratios.

ACCESS AND AVAILABILITY STANDARDS
(Continued)

Type of Practitioner	Ratio of Practitioners to Enrollees	Geographic Availability	Percent of Open Practices
Psychiatrists	(see footnote)[4]	*** MSA – Mileage** Level A – 1 in 15 miles Level B – 1 in 20 miles Level C – 1 in 25 miles Level D – 1 in 30 miles	(see footnote)[5]
Doctoral-level psychologists	(see footnote 6)	*** MSA – Mileage** Level A – 1 in 15 miles Level B – 1 in 20 miles Level C – 1 in 25 miles Level D – 1 in 30 miles	(See footnote 7)
Mental health nurse practitioners with furnishing numbers.	(see footnote 6) These practitioners fall under a general category of prescribers in the Access Standards run annually	These practitioners fall under a general category of prescribers in the Access Standards run annually	(See footnote 7)
Master's prepared therapists	(see footnote 6)	*** MSA – Mileage** Level A – 1 in 15 miles Level B – 1 in 20 miles Level C – 1 in 25 miles Level D – 1 in 30 miles	(See footnote 7)

[4] The Delegate does minimally require <u>all</u> membership to have access to at least one practitioner with an identified child specialty within specified geographic standards. The Delegate does <u>not</u> set separate standards for A) specific ratios of enrollees to child therapists or child prescribers or B) for geographic standards specific to specialty by the license level.

[5] The Delegate does not set standards for "Open Practices" percentages but rather monitors the network for access compliance quarterly, monitors for and responds to access complaints by increasing the network access as needed, makes best efforts to keep practitioners off of leave of absence status through rate and process negotiations and annually contacts those on leave to encourage a return to active status after they have placed themselves on leave.

ACCESS AND AVAILABILITY STANDARDS
(Continued)

Appointment Availability Standards	
Type of Services	**Standard**
Non-life-threatening Emergency	6 hours
Urgent Care	48 hours
Initial Post-hospitalization Follow-up Visit	7 days
Routine Visit	10 business days
Telephone Responsiveness Standards	
Telephone Availability	**Standard**
Triage and Referral	% of calls answered within 30 seconds, with a goal of 100%
Triage and Referral Abandonment Rate	Abandonment rate does not exceed 5%
Member Services Average Speed of Answer	% of calls answered within 30 seconds, with a goal of 100%
Member Services Abandonment Rate	Abandonment rate does not exceed 5%

B. Overview of Programs

The table below presents a brief overview of the Plan's operations in each of the four program areas that were examined during the Department's focused survey.

OVERVIEW OF PROGRAMS

PROGRAM	DESCRIPTION
ACCESS AND AVAILABILITY	• Enrollees receive a Supplement to the Combined Evidence of Coverage and Disclosure Form, appropriate to their benefit plan. The Supplement includes a "PBHC Schedule of Benefits," which clearly delineates "Severe Mental Illness Benefits" as separate and distinct from more general "Mental Health Services." The specific "severe mental illness" diagnoses are listed clearly. • Entry into outpatient services: The Delegate initially treats all requests for services as parity services for purposes of authorization of initial evaluation and treatment, with the exception of clear requests for only chemical dependency treatment. Initially, authorization is for four (4) visits with a non-physician provider and/or 12 visits with a physician provider without determining the diagnosis. If the enrollee has both parity and non-parity mental benefits, there is an auto-adjudication process for faxed requests for additional office visits and/or medication management visits from the provider that are accompanied by the appropriate completed Provider Assessment Report and, in the case of non-physician providers, the enrollee-completed Life Status Questionnaire. The auto-adjudication process automatically approves two (2) additional non-physician provider visits and/or six (6) additional physician visits without reviewing the diagnosis. For enrollees who have only parity mental visits, the system refers the request for staff review to determine whether the provider is requesting services for a parity diagnosis. Care Management staff may confer with the provider to clarify questions around possible parity diagnoses; e.g., dysthmia versus major depression. For subsequent requests for physician and non-physician visits and for all requests for other diagnostic or treatment services (e.g., psychological testing, intensive outpatient services), the provider must submit a Provider Assessment Request or contact the Delegate's care management staff for review of the medical necessity of the requested services and the benefits available to the enrollee.

ACCESS AND AVAILABILITY (Continued)	• The Delegate provides crisis intervention services in two ways:
	  ▪ If the enrollee calls the 24 hour telephone line, a master's prepared care manager will talk with the enrollee or the person calling (e.g., family member) to determine if the enrollee should go immediately to an appropriate emergency room or to a provider for an urgent care visit (which the care manager will arrange). In three (3) counties, The Delegate has a pilot program with a private vendor that can provide mobile crisis intervention services if appropriate.
	  ▪ If the enrollee presents directly to an emergency room, the Delegate pays for the psychiatric evaluation carried out in the emergency room
	The Delegate expects both psychiatrist and non-psychiatrist providers to have urgent care appointments available within six (6) hours of the enrollee's request for services. The Delegate also has agreements with specific providers through the service area that have agreed to provide evaluation services to enrollees who need such services on an urgent basis. The Delegate reimburses these providers a higher fee-for-service for providing these urgent evaluation services.
	• Voluntary admissions are prior-authorized through the care management system. If the enrollee calls directly and requests admission but is not in crisis, the care manager arranges for a psychiatrist to evaluate the enrollee and determine the appropriate level of care.
	• Involuntary admissions are usually done through the emergency room; the enrollee may be transported by law enforcement officers.
	• The Delegate provides intensive outpatient services when the enrollee does not need an inpatient level of care and routine outpatient care is not sufficient.
	• The Delegate provides residential treatment services as a parity benefit, if the enrollee's benefit plan includes residential treatment.
	• Enrollees with eating disorders may receive inpatient treatment on a medical unit if there are significant medical problems or on a mental health inpatient eating disorder unit, an intensive outpatient eating disorder program or a residential eating disorder treatment program, if the enrollee has a residential treatment benefit.
	• The Delegate does not contract with county-owned acute care or mental health facilities or programs with the exception of Stanislaus Behavioral Health and Recovery Services, which operates the Stanislaus Behavioral Health Center, with which it contracts for inpatient facility services and inpatient and outpatient facility services. However, the Delegate does pay claims from county facilities for emergency room services and emergency admissions that meet medical necessity criteria. This includes involuntary (5150) admissions.

ACCESS AND AVAILABILITY (Continued)	• The Delegate does not contract with Regional Centers for the provision of services, nor does it routinely refer enrollees to a Regional Center for services that the Delegate is required to provide under the parity legislation. The Delegate accepts evaluations and recommendations for autistic children from the Regional Centers and will arrange for the provision of those recommended services covered under parity. Delegate care managers will also inform parents about non-parity services that are available through the Regional Centers, such as parent support groups, parent education, and advocacy services.
UTILIZATION MANAGEMENT/ BENEFIT COVERAGE	• In addition to the outpatient service authorization process described above, the Delegate's care management staff prior-authorizes requests for inpatient care, partial hospitalization care, intensive outpatient care and residential treatment services. Electroconvulsive therapy and psychological testing also require prior-authorization. • The Delegate has a closed formulary. Certain drugs require prior-authorization to be covered. Retrospective review is limited to non-emergency services claims. • In addition to the utilization management processes described above, the Delegate has two focused care management programs: ▪ The Delegate's Assertive Care Management (ACM) program targets patients who are at high risk for hospitalization and/or who have had a history of multiple hospitalizations, poor psychosocial environment or poor adherence to treatment plans. The majority of patients in this program carry a parity diagnosis. The case manager in this program facilitates and assists in communication across all levels of care in behavioral health and between behavioral health and medical care. Information about primary care provider assignment of members is available to the Delegate. Additionally, linkages with the Plan's medical case management program are used. ▪ The Delegate's Extended Care Management (ECM) program is designed to provide less intensive post-discharge care management for a period of up to nine (9) months to help an enrollee adhere to the treatment and avoid re-hospitalization. • The Delegate manages enrolled children with autism and pervasive developmental delay (PDD) jointly with the Plan primary care physician (PCP) or primary medical group (PMG), and the Regional Centers or Early Intervention Centers, if the enrollee is receiving services from the Early Intervention Center or Regional Center. The PCP or PMG is responsible for the initial medical evaluation to rule out treatable medical conditions that may present similar to autism and PDD. The parents may then choose to have the initial evaluation of the autism and PDD performed by the Regional Center or the Delegate's delivery system. Autistic enrollees are placed in the Assertive Care Management program because of the need to help parents coordinate the variety of services that autistic children may require over time.

UTILIZATION MANAGEMENT/ BENEFIT MANAGEMENT (Continued)	Treatment includes family support and services as indicated, including speech and occupational therapies, medications, and family therapy and education. The Delegate, rather than the Plan, is responsible for the provision and payment of occupational and speech therapy services for autistic and PDD children. There is a specific care manager who works with the families of all autism-spectrum children who require speech and language therapy and/or occupational therapy.
CONTINUITY AND COORDINATION OF CARE	• The Delegate has adopted national clinical practice guidelines for parity diagnosis with assistance from the Plan's corporate resources and with practitioner input. These guidelines include: ▪ The American Psychiatric Association's practice guidelines for bipolar disorder, major depressive disorder, eating disorders, panic disorder and schizophrenia; ▪ The Expert Consensus Guideline Series: "Treatment of Obsessive Compulsive Disorder;" and ▪ The Academy of Child and Adolescent Psychiatry's "Practice Parameters for the Assessment and Treatment of Children Adolescents, and Adults with Autism and other Pervasive Developmental Disorders." • The Delegate collects and analyzes performance indicators related to practice guidelines: schizophrenia; major depression; and bipolar disorder. • The Delegate has established a Physician Consultation Line through which both medical providers and behavioral health providers can obtain telephonic consultation with a psychiatrist. • The Plan and the Delegate jointly developed educational material for primary care physicians related to the treatment of depression, entitled "The Taking Charge of Depression Program." • Other Delegate quality improvement activities focus on: ▪ Improving the timeliness of follow-up outpatient visits after hospitalization for mental illness; ▪ Reducing readmissions to acute inpatient mental health services; ▪ Improving antidepressant medication management; ▪ Improving member telephone access to the Delegate; ▪ Improving practitioner satisfaction with claims processing; ▪ Improving timeliness of member complaint resolution; and ▪ Improving access to initial routine appointments.

CONTINUITY AND COORDINATION OF CARE (Continued)	• The Delegate monitors coordination of care using strategies such as the following (and, where necessary, undertakes activities to improve performance): ▪ Semiannual audits of the Provider Assessment Requests to determine the rate at which behavioral health providers assessed enrollee compliance with medical treatment for enrollees identified as having one or more significant medical problems. ▪ Semiannual audits of the Provider Assessment Request for those enrollees needing care coordination to determine whether the mental health provider sent a Health Care Coordination Form to the primary care provider. ▪ An annual audit of the treatment records of five percent (5%) of the behavioral health providers for evidence of communication and coordination of care between the behavioral health practitioner and other behavioral health providers, primary care providers and/or ancillary providers. This audit includes measuring whether the mental health provider completed Health Care Coordination Forms and routed them to the appropriate practitioners.
DELEGATION MANAGEMENT	• The contract between the Plan and the Delegate and related delegation arrangements address the requirements for the Delegate to provide mental health services in accordance with the Mental Health Parity Act.

A P P E N D I X C

LIST OF STAFF INTERVIEWED

The following are the key Plan officers and staff who participated in the on-site survey at the Plan's administrative office on March 7 to 10, 2005:

PACIFICARE OF CALIFORNIA	
Name	**Title**
Nancy Monk	VP, State Government Affairs
Sharon Ricciuti, RN, MSN, MHSA	Director Quality Improvement
Debbie Salas	Director, Customer Service
Cheryl Tanigawa, MD	VP, Medical Director, Clinical Services
Christy Beaudin, Ph.D. LCSW, CPHQ	Corporate Director, Quality Improvement
Rich Irwin	Manager, Customer Service
Elizabeth Hays	Director, Regulatory Affairs
Althea Barber-Smith	VP, Appeals and Grievances
Cliff Hardesty	Director, Pharmacy Services
Caroline Iteen	Manager, Pharmacy Services

PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA, INC.	
Name	**Title**
Jerome Vaccaro, MD	President
Robert Burchuk, MD	VP, Medical Director, Health Service
Lawrence Weinstein, MD, ABHM	Medical Director
Teresa White, Ph.D., MBA, CPHQ	Quality Improvement Manager
Joan Aschoff, Psy.D.	Director, Utilization Management
Lori Pucci, LCSW	Manager, Clinical Operations
Sheila Lane	Director, Business Operations
Cathy Weflen	Manager, Claims
Jeanelle Coleman, MBA, CPHQ	Quality Improvement Manager
Carla Hix, Psy.D.	Clinical Supervisor, Customer Service
Scott Fowler	Manager, Appeals
Francis Orejudos	Project Manager, Regulatory Affairs

A P P E N D I X D

LIST OF SURVEYORS

The Department's Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Name	**Title**
Bobbie Reagan	Assistant Deputy Director, HMO Help Center
Marcy Gallagher, RN, MPA, JD	Chief, Division of Plan Surveys
Andrew George	Counsel, HMO Help Center
Tom Gilevich	Counsel, HMO Help Center
Dan McCord, MBA	Senior Health Care Service Plan Analyst
Anne Potter	Associate Health Care Service Plan Analyst

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Name	**Title**
Rose Leidl, RN	Contract Manager
Bernice Young	Program Director
Ruth Martin, MPH, MBA	Parity Survey Team Leader
Patricia Allen, M.Ed.	Data Analyst
Marshall Lewis, MD	Benefit Structure and Enrollee Information Surveyor
Erick Davis, MD, MPH, MBA	Utilization Management Surveyor
Mark Leveaux, MD	Quality Management Surveyor
Linda Velasquez, LCSW	Access and Availability Surveyor

A P P E N D I X E

STATUTES AND REGULATIONS APPLICABLE TO THE IDENTIFIED DEFICIENCES

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: The Plan's written policy does not correctly describe the Plan's obligations to provide coverage for the diagnosis and treatment of a person of any age with pervasive developmental disorder or autism in accordance with Section 1374.72. [Section 1374.72 (a)-(e), Rule 1300.74.72(e)]

Citations:
Section 1374.72 (a)-(e)
(a) Every health plan contract issued, amended, renewed on or after July 1, 2000, that provides hospital, medical or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).

(b) These benefits shall include the following:
- (1) Outpatient services.
- (2) Inpatient hospital services.
- (3) Partial hospital services.
- (4) Prescription drugs, if the plan contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:
- (1) Maximum lifetime benefits.
- (2) Copayments.
- (3) Individual and family deductibles.

(d) For the purposes of this section, "severe mental illnesses" shall include…(7) Pervasive developmental disorder or autism

Rule 1300.74.72(e)
Pervasive Developmental Disorders shall include Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's and Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders—IV—Text Revision (July 2000).

Deficiency 2: The Plan does not adequately monitor and evaluate accessibility of care, including the provision of after-hour services. [Rule 1300.67.2(b), Rule 1300.67.2(f), and Rule 1300.74.72(f)]

Citations:
Rule 1300.67.2(b)
Hours of operation and provision for after-hour services shall be reasonable.

Rule 1300.67.2(f)
Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments.

Rule 1300.74.72(f)
A health plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set for in Health and Safety Code section 1374.7.

B. UTILIZATION MANAGEMENT/BENEFIT COVERAGE

Deficiency 3: For benefit coverage denials, the Plan does not clearly specify the provision of the enrollee contract or Evidence of Coverage/Disclosure Form that excludes such coverage. [Section 1368(a)(5)]

Citation:
Section 1368(a)(5)
…If a plan, or one of its contracting providers, issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the enrollee, the decision shall clearly specify the provisions in the contract that exclude that coverage.

Deficiency 4: The Plan incorrectly and inappropriately denies emergency claims. [Section 1371.37 and Section 1371.4]

Citation:
Section 1371.37
"(a) A health care service plan is prohibited from engaging in an unfair payment pattern, as defined in this section.
(c) An "unfair payment pattern," as used in this section, means the following:
(1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays.
(2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.
(4) Failing on a repeated basis to automatically include the interest due on claims pursuant to section 1371

Section 1371.4

"Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that the health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition."

A P P E N D I X F

LIST OF ACRONYMS

Acronyms	Definition
CAP	Corrective Action Plan
DMH	Department of Mental Health
DOI	Department of Insurance
EOC	Evidence of Coverage
ER	Emergency Room
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases 9th Revision Clinical Modification
LCSW	Licensed Clinical Social Worker
MFT	Marriage and Family Therapist
MSA	Metropolitan Statistical Area
PBHC	PacifiCare Behavioral Health of California
PCC	PacifiCare of California
PCP	Primary Care Physician
PMG	Primary Medical Group
UM	Utilization Management

A P P E N D I X G

THE SURVEY PROCESS AND INSTRUCTIONS FOR THE PLAN'S CORRECTIVE ACTIONS AND RESPONSES

The following provides detail on the required survey activities and the order in which they are undertaken by the Department as well as instructions on how plans must institute corrective actions and prepare their responses to the Preliminary Report and the Final Report. The table below summarizes the survey activities and the corresponding timeframes.

FOCUSED SURVEY PROCESS

SURVEY ACTIVITY	TIMEFRAME
Focused Survey On-Site Visit Conducted	As needed
Preliminary Report due from the Department to the Plan	30 – 45 calendar days from the last day of the on-site visit
Response due from Plan to the Department [Section 1380(h)(2)] *(Included for each deficiency is to be evidence that the deficiency has been fully corrected)*	45 calendar days from date of receipt of Focused Survey Preliminary Report
Final Report due from the Department to the Plan	Within 170 days from the last day of the on-site visit
Response from Plan to Department on any matters in Final Report	Within 10 calendar days from receipt of Final Report. Response is included in Public File with Final Report
Final Report due from Department to the Public File [Section 1380(h)(1)]	Within 180 days from the last day of the on-site visit

Survey Preparation

The Department conducts a Focused Survey of a licensed health care service plan on an adhoc basis in order to evaluate a plan's compliance with certain Knox-Keene requirements and address specific issues identified by the Department. This Focused Survey specifically evaluates a plan's compliance with Section 1374.72.

Prior to the visit, the Department supplies the Plan with a Pre-On-Site Visit Questionnaire and a list of materials that the Plan is required to submit to the Department prior to the on-site visit. These materials are reviewed by the survey team to provide them with an overview of plan operations, policies and procedures in preparation for the visit. The Plan is also advised of the materials (e.g., case files, reports) the surveyors will review during the on-site visit so that these will be readily available for the survey team.

On-site Visit

During the on-site visit, the survey team reviews materials and conducts interviews with Plan staff and possibly with providers.

Preliminary Report

Specific to this Mental Health Parity Focused Survey, the Department provides the Plan with a Preliminary Report within 40 days of the on-site visit. The Preliminary Report details the Department's survey findings and the required corrective actions.

Plan's Response to the Preliminary Report

In accordance with Section 1380(h)(2), the Plan has 45 calendar days from the date of receipt of the Preliminary Report to file a written response. Preliminary and Final Reports are "deficiency-based" reports; therefore, only specific areas found by the Department to be in need of improvement are included in these Reports. Omission of other areas of the Plan's performance from the reports does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance in other areas.

All deficiencies cited in the Preliminary Report require corrective actions by the Plan. The Department specifies corrective actions in cases where factual findings of a deficiency constitute a violation of the Knox-Keene Act. The Plan must implement all required actions in the manner prescribed by the Department. The Plan must submit evidence that the required actions have been or are being implemented when the Plan submits its 45-day response.

The Plan's response should include the following information for each deficiency identified in the Preliminary Report:

(1) The Plan's response to the Department's findings of deficiencies;

(2) The Plan's response to the Department's specified corrective actions, which include a corrective action plan (CAP);

(3) Whether the CAP is fully implemented at the time of the Plan's response. If the CAP is fully implemented, the Plan should provide documents or other evidence that the deficiencies have been corrected; and

(4) If the CAP cannot be fully implemented by the time the Plan submits its response, the Plan should submit evidence that remedial action has been initiated and is on the way to achieving compliance. Please include a time-schedule for implementing the corrective action and a full description of the evidence the Plan will submit for the Department's follow-up review that will show the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The Plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the Plan's response indicates that the development and implementation of corrective actions will not be completed by the time the Plan files its 45-day response, the Plan should file any policies and procedures required for implementation as Plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the Plan should file both a clean and redline version of revised policies and procedures through the Department's web portal. The Plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the web portal. The Plan is not to submit its entire response to the Preliminary Report through the Department's web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review of the Plan's response to the Preliminary Report, the Department will publish a Final Report. This report will contain the survey findings as they were reported in the Preliminary Report, a summary of the Plan's response and the Department's determination concerning the adequacy of the Plan's response. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1). The Final Report will first be issued to the Plan, followed by a copy to the public file. The Final Report will be issued to the public file not more than 180 days from the conclusion of the on-site survey.

The Department will also issue a Summary of the Final Report to the public file at the same time it makes the Final Report available to the public. One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The Plan may submit additional responses to the Final Report and the Summary Report at any time before or after the reports are issued.